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Clients and Providers Need Better Support and Guidance on IUDs

Lack of knowledge among providers and clients, logistical problems, and cumbersome guidelines contributed to low use of the IUD in Ghana and Guatemala. Efforts to improve use should include more comprehensive training for providers, education for clients, and logistical support.

Background

The intrauterine device (IUD), e.g. the Copper T 380A, is a safe, effective and reversible contraceptive method that is appropriate for many women and provides protection for up to ten years. In many countries, however, use of the IUD is stagnant or declining in relation to other contraceptive methods. In 2002 Population Council investigated the reasons for low utilization of IUDs among women in Guatemala and Ghana. Both studies examined clients' and providers' knowledge and attitudes about IUDs as well as factors within the health system that affect their use and availability.

Methods Chosen by Family Planning Acceptors in Government Health Clinics, 2001

	Ghana (%)	Guatemala (%)
Injectable	54.7	67.0
Oral Contraceptives	25.3	12.9
Condom	11.1	9.6
IUD	***1.9***	***3.1***

Sources: Ghana Health Service Annual Report 2001; Guatemala Ministry of Public Health and Social Assistance service statistics, 2001.

The studies in Ghana and Guatemala took place at public, private, and non-governmental health centers and clinics in both rural and urban settings. Researchers in both countries collected qualitative data using a combination of focus group discussions, in-depth interviews with providers in Ghana and Guatemala, and visits from simulated clients enacting profiles of women wishing to space or limit pregnancies. The studies also included a secondary analysis of service statistics from government and private clinics to explore trends in IUD use in both countries.

Findings

Numerous factors among providers and clients, and within health care systems, contributed to the low demand for IUDs:

◆ *Provider knowledge and skills were inadequate in both countries*. In Guatemala, even though the majority of providers interviewed had received training in IUD insertion and removal, more than half had incorrect information about the method's side effects; almost one-third had misconceptions about when IUD use was contraindicated. In Ghana, less than a quarter of providers interviewed had received training on IUDs. Providers in both studies said they felt inadequate in maintaining their newly learned clinical skills because of the low demand for this method (only one or two insertions per month, in some areas).

◆ *Fear and misperceptions limited demand for IUDs among family planning clients.* Women in both countries mentioned legitimate side effects such as cramping and bleeding as reasons for not using the IUD. However, women have many

misconceptions about the IUD and its side effects: it causes marital disharmony, infertility, severe bleeding and even death. They also expressed apprehension about how such an object could be inserted into one's body.

◆ *Counseling on IUDs was often inadequate.* In Guatemala, less than half (41%) of providers offered information on IUDs to simulated clients interested in birth spacing. In Ghana, counseling on the IUD took place in almost three-quarters of provider-client interactions, but few mentioned a discussion of the IUD in the context of HIV/AIDS.

"The advent of AIDS makes wearing the IUD difficult since it only prevents pregnancy and not disease." —Provider, Ghana

◆ *The requirements for service provision limit availability of IUDs*. To provide IUD services, facilities need trained staff, a private examination area, proper equipment, and supplies. In Guatemala, close to 90 percent of government clinics and health centers had the necessary infrastructure and at least one worker trained in IUD insertion and removal, but about half lacked the supplies and equipment to offer this service. The reverse was true in Ghana, where only 56 percent of facilities had the infrastructure to offer IUDs but 91 percent had the necessary supplies available.

◆ *Clinical procedures and protocols limited access.* Focus group members in Guatemala said that the need to travel to urban clinics made IUDs too expensive. In Ghana, policies allow only midwives to insert IUDs, which also restricts access.

◆ *Client preferences are shifting.* Analysis of service records showed that the majority of family planning users in both countries prefer the injectable DMPA. Providers in Ghana also reported that fear of HIV/AIDS has led to an increase of condom use for protection against sexually transmitted infections.

Policy Implications

◆ Clinics serving populations that can support an adequate demand for IUDs need to have providers skilled in counseling, insertion and removal. It is important that providers have not only the necessary equipment and supplies but also a level of insertions per month that are sufficient to maintain their skills.

◆ To dispel rumors and to demystify the method, messages on the IUD should emphasize the positive attributes as well as the contraindications of the product and address the identified misconceptions.

◆ Clinical guidelines should be revised to incorporate the training of paraprofessionals and non-medical staff to increase access to IUDs among rural women.

◆ Counseling of potential clients should be provided that the IUD is a very good method for truly monogamous couples, and can be combined with condom use when a woman wants long-term avoidance of pregnancy but may be unsure of the HIV status of her partner(s). The IUD, when used with condoms, has also been approved by WHO for HIV positive women for whom pregnancy is very risky.

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John Gyapong et al. 2003. "An Assessment of Trends in the Use of the IUD in Ghana," FRONTIERS Final Report. Washington, D.C.: Population Council. For more information, contact: Population Council, General Accident Insurance House, P.O. Box 17643, 00500 Nairobi, Kenya. Tel: 254-2-271-3480; Fax: 254-2-271-3479; E-mail: publications@pcnairobi.org

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